

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: E. Mabini ARCH	CHAPTER 100.1
Address: 94-1083 Kuhaulua Street, Waipahu, Hawaii 96797	Date: February 17, 2016 Annual Inspection

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications</u>. (a) All medicines prescribed by physicians and dispensed by pharmacists shall be deemed properly labeled so long as no changes to the label have been made by the licensee, primary care giver or any ARCH/Expanded ARCH staff, and pills/medications are not removed from the original labeled container, other than for administration of medications. The storage shall be in a staff controlled work cabinet-counter apart from either resident's bathrooms or bedrooms.</p> <p>FINDINGS Resident #1, pharmacy bottle labels do not reflect orders:</p> <ol style="list-style-type: none"> 1. Physician order reads, "Clozapine <u>125 mg</u> one tablet <u>QHS</u>". However, two (2) bottle labels read, <ol style="list-style-type: none"> a) "Clozapine ODT 100 mg Dissolve 1 tablet by mouth <u>twice a day</u>" b) "Clozapine ODT <u>25 mg</u> Dissolve 1 tablet by mouth <u>every night at bedtime</u>". 	<p>In the future, CHO to ask pharmacists to create medication labels exactly as ordered by the MD. Then CHO to double check if labels match the doctors order before leaving the pharmacy.</p>	<p>2-22-2016</p>

	Rules (Criteria)	Plan of Correction	Completion Date
	2. Physician order reads, "Metformin XR 750 mg Sr 24 HR 1 QD with dinner". However, pharmacy label reads, "Metformin ER 750 mg 24 HR 1 QD".	In the future, CTO to ask pharmacists to create labels as ordered by the MD. CTO to double check labels before acceptance.	2-22-2016

☒	<p>§11-100.1-15 <u>Medications.</u> (m) All medications and supplements, such as vitamins, minerals, and formulas, when taken by the resident, shall be recorded on the resident's medication record, with date, time, name of drug, and dosage initialed by the care giver.</p> <p>FINDINGS Resident #1, progress note dated 2/3/16 reads, "Albuterol Sulfate 2 puffs given as ordered for SOB, continue to monitor". Physician order "Albuterol Sulfate 90 mcg/actuation HFAA 2 puff Q 4 hours for shortness of breath"; however, no initial to MAR for 2/3/16.</p>	<p>In the future, CTO to initial all medications given in the MAR, document in the progress notes as soon as it is administered. For medications given prn, CTO to document effectiveness of the drug in the MAR and in the progress notes.</p>	2-17-2016
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☒	<p>§11-100.1-23 <u>Physical environment.</u> (h) The Type I ARCH shall maintain the entire facility and equipment in a safe and comfortable manner to minimize hazards to residents and care givers.</p> <p>FINDINGS Resident #1, physician order reads, "prn oxygen concentrator and ventilator when saturation under 90%"; however,</p> <ol style="list-style-type: none"> 1 Bedroom #5, one (1) portable oxygen tank in an oxygen stand, stored in the closet. 2 No "Oxygen in Use" warning signs posted at the building entrance or outside Bedroom #5 door. 	<p>① Apria (supplier of the O2 tank) was notified to pick up the extra tanks and was removed from the care home on 2-17-2016.</p> <p>In the future, CTO to not accept more than 1 tank from the O2 supplier. One O2 concentrator + 1 portable tank attached to the concentrator is safe enough for the residents to move around in room.</p>	2-17-2016
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11-100.1-23 2-17-2016

② "O2 in Use" warning signs posted in the care home entrance and outside bedroom #5 door. All residents, caregivers notified of the O2 use and asked to refrain from smoking for safety of everyone. In the future, CTO to continue these safety measures and also to warn visitors to refrain from smoking.

<p><input checked="" type="checkbox"/> §11-100.1-23 <u>Physical environment. (i)(2)</u> All construction or alterations shall comply with current county building, land use and fire codes and ordinances in the state. The Type I ARCH licensed for wheelchair residents shall be accessible to and functional for the residents at the time of licensure.</p> <p>Windows shall have screens having no less than sixteen meshes per inch.</p> <p>FINDINGS Bedroom #7, no screen for window, above the air conditioner.</p>	<p>In the future, CTO to do a monthly check if window screens are still intact. If it is damaged or show signs of aging - to ask CTO's husband to replace the screen. In the future event that a resident asks for air-conditioner -</p>	<p>7-15-2016</p>
<p>that it is agreed upon - to install air conditioner and place a window screen above it.</p>	<p>continued</p>	
<p><input checked="" type="checkbox"/> §11-100.1-88 <u>Case management qualifications and services. (c)(6)</u> Case management services for each expanded ARCH resident shall be chosen by the resident, resident's family or surrogate in collaboration with the primary care giver and physician or APRN. The case manager shall:</p> <p>Coordinate care giver training, hospital discharge, respite, home transfers and other services as appropriate. Facilitate, advocate and mediate for expanded ARCH residents, care givers and service providers to ensure linkages and provision of quality care for the optimal function of the expanded ARCH resident;</p> <p>FINDINGS Resident #1, Case Manager identified problem "O2 Use Due to Impaired Respiratory Function". However, no training.</p>	<p>In the future, CTO to make sure that when there is a doctor's order to administer oxygen, RN case manager to provide training to all caregivers to administer oxygen as ordered for the safety of the resident and the care home.</p>	<p>7-18-2016</p>

Licensee's/Administrator's Signature: Eden Mabini

Print Name: Eden Mabini

Date: 7-18-2016

Licensee's/Administrator's Signature: Mabini

Print Name: Eden Mabini

Date: 8-21-2016